In The

SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1977

No. 77-772

JAMES M. DAWSON, Administrator of Northern New England Carpenters Health and Welfare Fund, New Hampshire Masons Health and Welfare Fund, New Hampshire Plumbers Health and Welfare Fund, New Hampshire Sheet Metal Works No. 297 Health and Welfare Fund,
PETITIONER.

vs.

FRANCIS E. WHALAND, Commissioner, Department of Insurance, State of New Hampshire,
RESPONDENT.

APPENDIX TO PETITION FOR WRIT OF CERTIORARI

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United States Court of Appeals for the First Circuit

No. 77-1135

BRUCE W. WADSWORTH, ADMINISTRATOR OF NEW HAMPSHIRE EMPLOYERS' BENEFIT TRUST AND NORTHERN NEW ENGLAND BENEFIT TRUST

APPELLANT,

v.

FRANCIS E. WHALAND, COMMISSIONER, DEPARTMENT OF INSURANCE, STATE OF NEW HAMPSHIRE

APPELLEE.

No. 77-1136

JAMES M. DAWSON, ADMINISTRATOR OF NORTHERN NEW ENGLAND CARPENTERS HEALTH AND WELFARE FUND, NEW HAMPSHIRE MASONS HEALTH AND WELFARE FUND, NEW HAMPSHIRE PLUMBERS HEALTH AND WELFARE FUND, NEW HAMPSHIRE SHEET METAL WORKERS # 297 HEALTH AND WELFARE FUND

APPELLANT,

v.

FRANCIS E. WHALAND, COMMISSIONER, DEPARTMENT OF INSURANCE, STATE OF NEW HAMPSHIRE

APPELLEE.

APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE DISTRICT OF NEW HAMPSHIRE

[HON. HUGH H. BOWNES, *United States District Judge*]

WADSWORTH ET AL. *v.* WHALAND

Before COFFIN, *Chief Judge*,
LAY, *Circuit Judge**,
CAMPBELL, *Circuit Judge*.

David L. Nixon, with whom *Randolph J. Reis* and *Brown and Nixon Professional Association* were on brief, for James M. Dawson, etc., appellant.

John J. Flaherty, with whom *Peter H. Ryeman* and *Preti & Flaherty* were on brief, for Bruce W. Wadsworth, appellant.

George J. Pantos, *Michael J. Bartlett*, *Fedder, Price, Kaufman, Kammholz & Day* and *Robert S. Stone* on brief, for Erisa Industry Committee, amicus curiae.

James C. Sargent, Jr., Assistant Attorney General, with whom *David H. Souter*, Attorney General, and *Andrew R. Grainger*, Attorney, were on brief, for appellees.

Warren Spannaus, Attorney General, *Richard B. Allyn*, Solicitor General, *Richard A. Lockridge*, and *Stephen Shakman*, Special Assistant Attorneys General, on brief for the State of Minnesota, amicus curiae.

September 1, 1977

LAY, *Circuit Judge*. This case presents an important and fundamental question of federal preemption because of an alleged conflict between the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. § 1001 et seq., and the New Hampshire state law regulating the content of group insurance policies, Chapter 57 of the Laws of 1976, N.H. Rev. Stat. Ann. §§ 415:18-a, 419:5-a and 420:5-a (1976). Chapter 57 requires the "issuers" of group health insurance policies to provide coverage for the treatment of mental illnesses and emotional disorders.[1] ERISA does not require this. Administrators of various health and welfare funds which provide benefits chiefly through the purchase of group health insurance,[2] brought

* Of the Eighth Circuit, sitting by designation.

[1] *Each insurer that issues or renews any policy* of group or blanket accident or health insurance providing benefits for medical or hospital expenses, shall provide to each group, or to the portion of each group comprised of certificate holders of such insurance who are residents of this state and whose principal place of employment is in this state, coverage for expenses arising from the treatment of mental illnesses and emotional disorders . . . .
N.H. Rev. Stat. Ann. § 415:18-a(I) (1976) (emphasis added).

[2] Northern New England Carpenters Health and Welfare Fund, New Hampshire Masons Health and Welfare Fund, New Hampshire Plumbers Health

this action against Francis E. Whaland, Commissioner of Insurance for the State of New Hampshire, seeking a declaration that Chapter 57 is unconstitutional and an injunction restraining its enforcement. The fund administrators' principal contention is that ERISA preempts the provisions of Chapter 57, to the extent that that chapter applies to employee benefit plans.[3] Alternatively, they assert that the New Hampshire statutory scheme is an undue burden on interstate commerce and violates the due process and equal protection clauses of the United States Constitution. Both parties filed motions for summary judgment. After an evidentiary hearing relating primarily to the issue of irreparable harm, the district court, the Honorable Hugh H. Bownes presiding, held that ERISA did not preempt state regulation of group insurance policies, and that Chapter 57 did not contravene any provision of the Constitution. We affirm.

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and Welfare Fund, New Hampshire Sheet Metal Workers #297 Health and Welfare Fund, New Hampshire Employers' Benefit Trust, and Northern New England Benefit Trust.

[3] The importance of the preemption issue is highlighted by the participation of the ERISA Industry Committee (ERIC) and the State of Minnesota as amicus curiae. The State of Minnesota recently enacted a comprehensive health insurance law which requires certain minimum health-care benefits. *See* Minnesota Comprehensive Health Insurance Act, Minn. Stat. Ann. Ch. 62E (West Supp. 1977). The State of Minnesota stresses the overall importance of the continued efficacy of state insurance laws, as recognized by § 514(b)(2)(B) of ERISA, 29 U.S.C. § 1144(b)(2)(B), and as required by the McCarran-Ferguson Act, 15 U.S.C. §§ 1011-15. ERIC, a nonprofit association of 80 major corporations who maintain group health plans covering nearly 7 million employees, joins the plaintiff administrators in urging that ERISA preempts state laws which directly or indirectly "relate" to employee welfare plans. Such a result is required, they believe, to avoid the substantial, adverse effects of concurrent federal and multiple state regulation of welfare benefit plans. The ERIC brief concludes with this comment:

> In the final analysis, the victims of a fragmented scheme of Federal and multi-state regulation of benefit plans are likely to be employees, themselves — the very persons intended to be benefited by plan regulation. Faced with mounting costs, unwieldy administration and vexatious litigation, at least some employers will undoubtedly terminate or curtail their employee welfare benefit plans; others, considering the adoption of such plans, will abandon the idea. Such a result would not only be directly contrary to the best interest of employees but also frustrate Congressional intent in adopting ERISA as a mechanism for encouraging the growth of employee benefit plans.

I.

ERISA.

As the preamble to the Act indicates,[4] ERISA is the result of a congressional endeavor to curb the funding and disclosure abuses of employee pension and welfare benefit plans by establishing minimum federal standards. Title I of ERISA, composed of five main subparts, provides the substantive regulatory provisions governing two basic types of employee benefit plans. Those two types are *pen-*

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[4] Section 2 of ERISA states:

(a) The Congress finds that the growth in size, scope, and numbers of employee benefit plans in recent years has been rapid and substantial; that the operational scope and economic impact of such plans is increasingly interstate; that the continued well-being and security of millions of employees and their dependents are directly affected by these plans; that they are affected with a national public interest; that they have become an important factor affecting the stability of employment and the successful development of industrial relations; that they have become an important factor in commerce because of the interstate character of their activities, and of the activities of their participants, and the employers, employee organizations, and other entities by which they are established or maintained; that a large volume of the activities of such plans is carried on by means of the mails and instrumentalities of interstate commerce; that owing to the lack of employee information and adequate safeguards concerning their operation, it is desirable in the interests of employees and their beneficiaries, and to provide for the general welfare and the free flow of commerce, that disclosure be made and safeguards be provided with respect to the establishment, operation, and administration of such plans; that they substantially affect the revenues of the United States because they are afforded preferential Federal tax treatment; that despite the enormous growth in such plans many employees with long years of employment are losing anticipated retirement benefits owing to the lack of vesting provisions in such plans; that owing to the inadequacy of current minimum standards, the soundness and stability of plans with respect to adequate funds to pay promised benefits may be endangered; that owing to the termination of plans before requisite funds have been accumulated, employees and their beneficiaries have been deprived of anticipated benefits; and that it is therefore desirable in the interests of employees and their beneficiaries, for the protection of the revenue of the United States, and to provide for the free flow of commerce, that minimum standards be provided assuring the equitable character of such plans and their financial soundness.

(b) It is hereby declared to be the policy of this Act to protect interstate commerce and the interests of participants in employee benefit and their beneficiaries, by requiring the disclosure and reporting to participants and beneficiaries of financial and other information with respect thereto, by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal courts.

29 U.S.C. § 1001(a) - 1001(b).

sion plans, which provide for retirement or deferred income,[5] and *welfare* benefit plans, which provide medical, health, sickness, accident, and other non-pension benefits.[6]

Part one of Title I[7] deals with the reporting and disclosure requirements for both types of plans. The basic purposes of these requirements are to inform employees of their rights, and to assist the Secretary of Labor in determining the financial soundness of the plan. *See* Brummond, *Federal Preemption of State Insurance Regulation Under ERISA*, 62 Iowa L. Rev. 57, 61-62 (1976). Thus, the fund administrators are required to provide each participant and each beneficiary with a summary description of their plan drafted in language understandable by the average plan participant and to make available a copy of the plan's annual report.[9] A copy of the information provided to participants and beneficiaries, as well as other data, must be furnished to the Secretary of Labor.[10]

Parts two[11] and three[12] of Title I are limited in that they apply only to pension benefit plans. Part two creates minimum vesting standards and participation requirements, while part three provides funding requirements.

Part four[13] of the Title sets forth the fiduciary standards for the management of employee pension and welfare benefit plans. These standards provide in part that the plan be in writing,[14] the assets be held in trust[15] exclusively for the benefit of employees,[16] and that the plan investments

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[5] 29 U.S.C. § 1002(2).
[6] 29 U.S.C. § 1002(1).
[7] 29 U.S.C. §§ 1021-31.
[8] 29 U.S.C. § 1022(a)(1).
[9] 29 U.S.C. § 1023(a)(1)(A).
[10] 29 U.S.C. § 1021(b).
[11] 29 U.S.C. §§ 1051-61.
[12] 29 U.S.C. §§ 1081-86. For further discussion of subpart three see Brummond, *Federal Preemption of State Insurance Regulation Under ERISA*, 62 Iowa L. Rev. 57, 62-63 (1976).
[13] 29 U.S.C. §§ 1101-14.
[14] 29 U.S.C. § 1102(a)(1).
[15] 29 U.S.C. § 1103(a).
[16] 29 U.S.C. § 1104(a)(1)(A)(i).

be diversified.[17] A "prudent man" standard is established for fund administrators, and prohibited financial transactions are listed.[18]

Finally, part five[19] contains the administrative and enforcement provisions which apply to both employee pension plans and welfare benefit plans. It creates broad criminal and civil penalties[20] and sets forth general guidelines governing claims procedures.[21] Part five also gives the Secretary of Labor broad investigative powers[22] and authority to promulgate regulations.[23]

II.

The "Funds".

The funds administered by plaintiffs are employee welfare benefit plans within the meaning of § 3 of ERISA.[24] All of the funds, with the exception of New Hampshire Employer's Benefit Trust, are "Taft-Hartley Trusts" in that they are also regulated by § 302 of the Labor Management Relations Act.[25] Also with the exception of New Hampshire Employer's Benefit Trust, which is voluntarily operated by employees, the funds are the products of collective bargaining agreements that require employers to contribute at a specified level. While the level of contributions is specified by the collective bargaining agreements, benefits are not.

Each year the fund administrators meet with local unions to determine the types of coverage desired by the members. The fund administrators must obtain, at the least possible cost, the coverage chosen. To fulfill this ob-

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[17] 29 U.S.C. § 1104(a)(1)(C).
[18] 29 U.S.C. §§ 1104(a)(1)(B), 1106.
[19] 29 U.S.C. § 1131-44.
[20] 29 U.S.C. §§ 1131-32.
[21] 29 U.S.C. § 1133.
[22] 29 U.S.C. § 1134.
[23] 29 U.S.C. § 1135.
[24] 29 U.S.C. § 1002(1).
[25] 29 U.S.C. § 186(c).

ligation the fund administrators, with the aid of insurance consultants, put together packages upon which they request sealed bids from insurance companies. Although the funds are self-insurers on a few benefits, approximately 90 per cent of the benefits are provided through group insurance policies. However, for all practical purposes, under the group insurance policies the funds are self-insurers who retain the insurance companies to provide the administrative service of processing claims.[26] Because the premiums are experience rated the amount of claims for the year is projected; if the actual amount of claims is higher than the projection, the premium is adjusted upward; if the actual amount of claims is lower than the projection, the premium is adjusted downward. So in the long run, the funds reimburse the insurance company for all claims.

III.

A. *The Preemption Issue.*

The preemption issue is raised by § 514 of ERISA[27] which provides that all state laws that "relate to" employee benefit plans are superseded.[28] This sweeping lan-

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[26] In *General Electric Co. v. Gilbert*, 429 U.S. 125 (1976), the Supreme Court made a similar observation concerning General Electric's "Weekly Sickness and Accident Insurance Plan:"

> With respect to the Plan, General Electric is, in effect, a self-insurer. While General Electric has obtained, for employees outside California, an insurance policy from the Metropolitan Life Insurance Company, this policy involves the payment of a tentative premium only, subject to adjustment in the light of actual experience. Pretrial Stipulation of Facts, ¶ 11. In effect, therefore, the Metropolitan Life Insurance Company is used to provide the administrative service of processing claims, while General Electric remains, for all practical purposes, a self-insurer.

429 U.S. at 129 n. 3.

[27] 29 U.S.C. § 1144.

[28] Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall *supersede* any and *all* State laws insofar as they may now or hereafter *relate to* any employee benefit plan. . . .

29 U.S.C. § 1144(a) (emphasis added).

guage is modified by a saving clause which reaffirms the authority of the states to regulate insurance.[29] However, the saving clause is further limited in that no plan will be "deemed" to be an insurance company, insurer or engaged in the business of insurance for the purpose of any state insurance law.[30]

Plaintiffs contend that § 514 preempts any *direct or indirect* regulation of employee benefit plans by the state.[31] They urge that Chapter 57 clearly "relates" to employee benefit plans and therefore the provisions of ERISA "supersede" Chapter 57 as it applies to them. On the other hand the Commissioner urges that no direct conflict between ERISA and Chapter 57 exists, and that the saving clause specifically preserves the efficacy of state regulation of insurance. The Commissioner finds support for his position in the McCarran-Ferguson Act[32] which reflects a con-

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[29] Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from *any law of any State which regulates insurance*, banking, or securities.

29 U.S.C. § 1144(b)(2)(A) (emphasis added).

[30] Neither *an employee benefit plan* described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, *shall be deemed to be an insurance company or other insurer*, bank, trust company, or investment company *or to be engaged in the business of insurance* or banking *for purposes of any law of any State purporting to regulate insurance companies, insurance contracts*, banks, trust companies, or investment companies.

29 U.S.C. § 1144(b)(2)(B) (emphasis added).

[31] In making this contention plaintiffs rely on the definitions of "State law" and "State" contained in § 514(c), which provides:

> (2) The term "State" includes a State, any political subdivisions thereof, or any agency or instrumentality of either, *which purports to regulate, directly or indirectly, the terms and conditions of employee benefit plans* covered by this subchapter.

29 U.S.C. § 1144(c) (emphasis added).

[32] 15 U.S.C. §§ 1011-15. In particular, § 2(b) of the McCarran-Ferguson Act, provides:

> No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, *unless such Act specifically relates to the business of insurance* . . . .

15 U.S.C. § 1012(b) (emphasis added).

gressional policy to allow the states to regulate the business of insurance.[33]

B. *The New Hampshire Act.*

In resolving the preemption issue, it is first necessary to determine the scope of the New Hampshire statute. Chapter 57 applies to "each insurer that issues or renews any policy of group or blanket accident or health insurance" and "certificate holders of such insurance." The issue is whether employee welfare funds are insurers under the statute. In the event they are, we would have no difficulty finding explicit preemption by ERISA notwithstanding the saving clause.[34]

In determining the scope of Chapter 57 we are without the aid of a definitive New Hampshire state court interpretation. The state attorney general, without conceding its direct non-applicability to employee benefit plans, indicates that "Chapter 57 is not a disclosure law, and it does not purport to regulate benefit plans." The plaintiffs, on the other hand, assert that they are not "self-insurers," despite the fact that their insurance premiums are experience rated. Without further clarification we find that Chapter 57 was codified as an insurance law and specifically relates to insurers who issue certificates of insurance. Under a group insurance policy, a plan, as such, is really the "insured" and it does not issue certificates of insurance to its

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[33] Section 514(d) of ERISA reaffirms the congressional policy set forth in the McCarran-Ferguson Act by providing:

> (d) Nothing in this subchapter shall be construed to alter, amend, modify, invalidate, impair, or supersede any law of the United States (except as provided in sections 1031 and 1137(b) of this title) or any rule or regulation issued under any such law.

29 U.S.C. § 1144(d).

[34] As we will discuss, the preemption clause makes explicit that "all State laws" as they "relate" to "any employee benefit plan" are "superseded." Additionally, § 514(b)(2)(B) clearly removes an employee welfare plan from the application of the saving clause. *Hewlett-Packard Co. v. Barnes*, 425 F. Supp. 1294 (N.D. Cal. 1977).

members. Under these circumstances we find there is no intention under Chapter 57 to directly regulate employee welfare plans as insurers.

This resolution, however, does not end our analysis. Plaintiffs further contend that Chapter 57 impermissibly regulates employee benefit plans by indirectly regulating the content of the group insurance policies which the funds purchase, and that ERISA preempts any indirect state regulation of employee benefit plans. The State of New Hampshire responds that ERISA was not intended to preempt any state law unless that law directly conflicts with or duplicates the regulatory provisions of ERISA.

C. *Legislative History of § 514(a).*

We turn first to the state's argument. New Hampshire contends that Congress' use of the word "supersede" in § 514(a) indicates an intention to avoid regulatory vacuums created by displacing state regulation only in areas not principally covered by ERISA.[35] We disagree. The legislative history manifests that Congress intended to preempt all state laws that *relate* to employee benefit plans and not just state laws which purport to regulate an area expressly covered by ERISA.

The original versions of ERISA, both in the House and Senate, limited the scope of preemption to areas expressly covered by the bill. The House version listed the specific areas of federal regulation; the Senate version preempted all state laws which were related to the "subject matter" regulated by the bill.[36] However, during conference the

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[35] This argument was made by Brummond. *See* Brummond, *supra*, 62 Iowa L. Rev. at 99.

[36] Section 514(a) of H.R. 2, 93d Cong., 1st Sess. (1973) provided:

> (a) It is hereby declared to be the express intent of Congress that, except for actions authorized by section 503(e)(1)(B) of this Act and except as provided in subsection (b) of this section the *provisions of part 1 of this subtitle shall supersede any and all laws of the States and*

language limiting preemption was replaced by the present sweeping preemption language. The conference committee report and the floor debates explain that the reason for the change was to avoid "the possibility of endless litigation over the validity of State action that might impinge on Federal regulation . . . and potentially conflicting State laws hastily contrived to deal with some particular aspect of private welfare or pension benefit plans not clearly connected to the Federal regulatory scheme."[37] Congress, therefore, clearly rejected a concept of preemption limited to conflicting or duplicate state law, in favor of applying the principle in its "broadest sense."[38]

Thus, we agree with plaintiffs that Chapter 57 is a state law which indirectly relates to employee benefit plans and is subject to preemption. However, we cannot agree that preemption necessarily follows. Chapter 57 is also a state law regulating insurance and is expressly exempted from preemption by § 514(b)(2)(A).[39] Any possible conflict

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of political subdivisions thereof insofar as they may now or hereafter relate to the reporting and disclosure responsibilities, and fiduciary responsibilities, of persons acting on behalf of any employee benefit plan to which part 1 applies.

120 Cong. Rec. 4742 (1974) (emphasis added).

Section 699(a) of the Senate version provided:

(a) PRE-EMPTION OF STATE LAWS. — It is hereby declared to be the express intent of Congress that, except for actions authorized by section 694 of this title, the provisions of this Act or the Welfare and Pension Plans Disclosure Act *shall supersede any and all laws of the States and of political subdivisions thereof insofar as they may now or hereafter relate to the subject matters regulated by this Act or the Welfare and Pension Plans Disclosure Act.* . . .

120 Cong. Rec. 5002 (1974) (emphasis added).

[37] 120 Cong. Rec. 29942 (1974) (remarks of Sen. Javits). *See also* H.R. No. 93-1280, 93d Cong., 2d Sess. (1974), *reprinted in* [1974] U.S. Code Cong. & Admin. News 5038; S.R. No. 93-1090, 93d Cong., 2d Sess. (1974); 120 Cong. Rec. 29197 (1974) (remarks of Rep. Dent); 120 Cong. Rec. 29933 (1974) (remarks of Sen. Williams). For an excellent discussion of the legislative history see *Hewlett-Packard Co. v. Barnes*, 425 F. Supp. 1294, 1298-1300 (N.D. Cal. 1977).

[38] 120 Cong. Rec. 29197 (1974) (remarks of Rep. Dent).

[39] Section 514(b)(2)(A) provides that ERISA does not relieve any "person" from any state insurance law. 29 U.S.C. § 1144(b)(2)(A). Included within the definition of "person" are trusts created under such a plan.

between the state's regulation of insurance and the regulatory provisions of ERISA must be resolved by the application of the "deemer" clause, § 514(b)(2)(B).

D. *The "Deemer" Clause.*

The deemer clause simply provides that a state may not deem an employee benefit plan to be an insurance company, insurer, or in the business of insurance for the purposes of its insurance laws. Consequently, a state may not regulate an employee benefit plan simply because the plan serves as self-insurer on all of its benefits. Thus, the deemer provision prevents a state from subjecting a plan, as a business of insurance, to the state's general insurance laws or enacting special legislation regulating plans as a "unique variety of insurance." *Hewlett-Packard Co.* v. *Barnes*, 425 F. Supp. 1294, 1300 (N.D. Cal. 1977). However, on its face the deemer provision does not prohibit a state from indirectly affecting plans by regulating the contents of group insurance policies purchased by the plans.

We are unable to accept plaintiffs' contention that the deemer provision forbids the states from indirectly affecting employee benefit plans by regulating group insurance. In order to accept plaintiffs' construction, we would have to construe § 514 without its saving clause pertaining to state regulation of insurance. This we cannot do; we must interpret the statute as written. Congress was fully aware of the functions and scope of employee benefit plans[40] and, nonetheless, exempted state laws regulating insurance from preemption. We also find that plaintiffs' suggested construction is not required by the definition of "State" as any state agency which "purports to regulate, directly or indirectly, the terms and conditions of employee benefit plans covered by this title." ERISA § 514 (c)(2). Such a

[40] Congress defined an employee benefit plan as one providing benefits "through the purchase of insurance or otherwise." 29 U.S.C. § 1002(1).

construction would completely emasculate the saving clause. It is our duty when interpreting an act of Congress to construe it in such a manner as to give effect to all its parts and to avoid a construction which would render a provision surplusage. *See, e.g., McDonald v. Thompson,* 305 U.S. 263 (1938); *Wilderness Society v. Morton,* 479 F.2d 842 (D.C. Cir. 1973), *cert. denied,* 411 U.S. 917 (1973).

The plaintiffs' interpretation would greatly diminish the state's primacy in regulating insurance. It would nullify all state insurance laws concerning group insurance when the group policy is issued to an employee benefit plan. We do not find, absent a clear statement of intent, that Congress meant to so restrict a state's authority to regulate insurance. *Cf. United States v. Bass,* 404 U.S. 336, 350 (1971).

Our interpretation of the deemer provision comports with the national policy of state primacy in the regulation of insurance announced by Congress in the McCarran-Ferguson Act.[41] Under that Act, the only congressional enactment which may "invalidate, impair, or supersede" any state insurance law is an act which "specifically relates to the business of insurance. . . ."[42] This national policy is twice reaffirmed by ERISA in § 514: first with the saving clause, and again with subsection (d).

We conclude that ERISA does not preempt application of state law to group insurance policies when such policies are purchased by employee benefit plans. The argument that the plans would be detrimentally affected and might

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[41] 29 U.S.C. § 1011-15. In the landmark decision of *Paul v. Virginia,* 75 U.S. (8 Wall.) 168 (1868), the Supreme Court held that "[i]ssuing a policy of insurance [was] not a transaction of commerce." *Id.* at 183. However, in 1944 the Supreme Court reversed *Paul v. Virginia, supra,* in *United States v. South-Eastern Underwriters Ass'n,* 322 U.S. 533 (1944), holding that the business of insurance was interstate in nature. *Id.* at 539. The decision cast considerable doubt on the validity of the entire state insurance regulatory mechanism. The McCarran-Ferguson Act dispelled the doubt, however, by reaffirming the ascendency of state regulation in insurance matters.

[42] 29 U.S.C. § 1012.

face bankruptcy or extinction cannot change the plain meaning of ERISA. Assuming such detrimental consequences exist, we note that Congress fully intended to appraise the implementation of the Act and to provide remedial legislation where necessary.[43] In any event such arguments are not best directed to the courts.

IV.

Other Issues.

We briefly review the appellants' remaining arguments. The fund administrators challenge the application of Chapter 57 to employee welfare funds claiming it to be preempted by the National Labor Relations Act and in contravention of the Constitution of the United States. We find no merit to these claims and, as did the district court, we dispose of them summarily.

Plaintiffs argue that Chapter 57, since it indirectly affects employee welfare funds, is preempted by general provisions of federal labor law. As we have indicated, Chapter 57 does not relate to employee benefit plans and is not intended to affect labor relations or disputes. The record demonstrates that benefits under any insurance plan are not part of the terms or conditions of collective bargaining agreements. Similarly, it has been held that state regulation of pension plans is not preempted by federal labor law. *White Motor Corp. v. Malone*, 545 F.2d 599 (8th Cir. 1976). State regulations of group insurance policies purchased by employee benefit plans are peripheral to any federal labor law other than ERISA.[44]

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[43] An indication of this continuing concern was Congress' direction that a task force be formed to study and make a full report on "the effects and desirability of Federal preemption of state and local law with respect to matters relating to pension and similar plans. . . ." 29 U.S.C. § 1222(a)(4).

[44] The McCarran-Ferguson Act provides that no state insurance law is to be superseded by federal law unless that law specifically relates to the business of insurance. 29 U.S.C. § 1012. The Labor Management Relations

Plaintiffs additionally assert that Chapter 57 is an unconstitutional burden on interstate commerce. This claim is partially refuted by the fact that Congress fully intended in passing ERISA to retain regulation of insurance within the sphere of the state. There is no proof of any undue burden on commerce.

In *State Board of Ins. v. Todd Shipyards Corp.*, 370 U.S. 451 (1962), the Supreme Court held: "The power of Congress to grant protection to interstate commerce against state regulation or taxation [citations omitted], *or to withhold it* [citations omitted] is so complete that its ideas of policy should prevail." *Id.* at 456 (emphasis added and footnote omitted). The Court further noted that with the McCarran-Ferguson Act Congress "provided that the regulations and taxation of insurance should be left to the States, without restriction by reason of the Commerce Clause." *Id.* at 452.

Plaintiffs also challenge Chapter 57 on due process grounds. The district court found that New Hampshire law does not subject the fund administrators to any criminal penalty for noncompliance with Chapter 57. On this basis it determined that plaintiffs had no legal basis to attack the New Hampshire Act for vagueness. We agree. "The essential purpose of the 'void for vagueness' doctrine is to warn individuals of the criminal consequences of their conduct." *Jordon v. DeGeorge*, 341 U.S. 223, 230 (1951).

Act, 29 U.S.C. § 141 et seq., is not a law that specifically relates to the business of insurance. The Labor Management Relations Act does place some restrictions upon so-called "Taft-Hartley Trusts" including a requirement that the trustees provide "fair and equal treatment." 29 U.S.C. § 186. Plaintiffs claim that this duty cannot be satisfied if Chapter 57 is upheld since union members in New Hampshire will be receiving disproportionate benefits. New Hampshire responds that this duty is satisfied when a trustee pays out a given *level* of benefits to employees which is relatively uniform, equitable, and which comports with the level of contributions; and that appellant has no obligation under 29 U.S.C. § 186 to provide the *same type* of benefits to all employees.

With regard to plaintiffs' equal protection argument, the district court found that, since they were not insurance companies, the plaintiffs lacked standing to challenge the New Hampshire Act as being in violation of the equal protection clause of the Constitution. We are hesitant to exclude plaintiffs' challenge on a finding of lack of standing. As Judge Stevens (now Mr. Justice Stevens) observed in *Cotovsky-Kaplan Physical Therapy Ass'n, Ltd. v. United States*, 507 F.2d 1363 (7th Cir. 1975): "The test is not whether these plaintiffs are regulated by the statute but whether the interests asserted by them arguably fall within the zone of interests so regulated." *Id.* at 1366.

However, we need not decide the standing issue. Even assuming standing, we summarily hold that plaintiffs' argument that the statute denies equal protection since it discriminatorily favors Blue Cross-Blue Shield, to be without merit. *See Travelers Ins. Co. v. Blue Cross*, 481 F.2d 80, 86 (3d Cir. 1973).[45]

The judgment is affirmed.

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[45] The equal protection issue was fully briefed and argued in both the district court and this court and was implicitly rejected by the district court. Thus, our decision is not contrary to the principle enunciated in *Singleton v. Wulff*, 428 U.S. 106 (1976), urging that appellate courts forego passing on constitutional issues not decided by the district court.

Appendix "B"

UNITED STATES DISTRICT COURT FOR THE DISTRICT OF NEW HAMPSHIRE

James M. Dawson, Administrator of Northern New England Carpenters Health and Welfare Fund, New Hampshire Masons Health and Welfare Fund, New Hampshire Plumbers Health and Welfare Fund, New Hampshire Sheet Metal Workers No. 297 Health and Welfare Fund, and Bruce W. Wadsworth, Administrator of New Hampshire Employers' Benefit Trust and Northern New England Benefit Trust

v.

Francis E. Whaland, Commissioner, Department of Insurance, State of New Hampshire

CIVIL ACTION
No. 76-266

ORDER

Plaintiffs are administrators of employee health and welfare funds, all but one of which, the New Hampshire Employers' Benefit Trust, are "Taft-Hartley Trusts" established under 29 U.S.C. § 186(c).

The defendant, the State of New Hampshire, has recently enacted Chapter 57 of the Laws of 1976, RSA 415:18-a, 419:5-a, and 420:5-a, which mandates coverage of mental and nervous conditions in group health and accident insurance policies.

The plaintiffs claim that the New Hampshire statute violates the United States Constitution and that it is preempted by federal statutes in the instances of the Taft-Hartley Trusts.

The plaintiffs allege that several provisions of Chapter 57 violate the equal protection and due process provisions of the Fourteenth Amendment. The case is before this court on cross-motions for summary judgment.

In determining whether Chapter 57 violates the Equal Protection Clause, I must uphold the legislative classification unless it is patently arbitrary and bears no rational relationship to a legitimate governmental interest. *U.S. Dept. of Agriculture v. Moreno*, 413 U.S. 528 (1973); *Frontiero v. Richardson*, 411 U.S. 677 (1973); *San Antonia Independent School District v. Rodriquez*, 411 U.S. 1 (1973); *Dandridge v. Williams*, 397 U.S. 471 (1970); *Turner v. Fouche*, 396 U.S. 346 (1970). "This inquiry employs a relatively relaxed standard reflecting the Court's awareness that the drawing of lines that create distinctions is peculiarly a legislative task and an unavoidable one." *Massachusetts Board of Retirement v. Murgia*, 44 U.S.L.W. 5077 (1976). I look to the character of the classifications in question, individual interests affected by classification, and governmental interests asserted in support of classification. *Dunn v. Blumenstein*, 405 U.S. 330 (1972). In doing so, I note that the exercise of the police power with regard to enforcement of health and insurance regulations is almost always upheld. *Cf. Hoopston Canning Co. v. Cullen*, 318 U.S. 313 (1943); *Bourjois v. Chapman*, 301 U.S. 183 (1937); *Travelers Insurance Co. v. Blue Cross of Western Pennsylvania*, 481 F.2d 80 (3d Cir. 1973), *cert. den.*, 414 U.S. 1093 (1973); *Iowa National Mutual Insurance Company v. City of Osawatomie, Kansas*, 458 F.2d 1124 (10th Cir. 1972); *Wissner v. Metropolitan Life Insurance Company*, 395 F.2d 204 (5th Cir. 1968); *Guest v. Fitzpatrick*, 409 F. Supp. 818 (E.D. Pa. 1976); *King v. Blue Mountain Forest Association*, 100 N.H. 212 (1956); *State v. Normand*, 76 N.H. 541 (1913). Justice Holmes stated with regard to the guarantees of the Fourteenth Amendment and the reservation of the police powers to the State:

> [W]e must be cautious about pressing the broad words of the Fourteenth Amendment to a drily logical extreme. Many laws which it would be vain to ask the court to overthrow could be shown, easily enough, to transgress a scholastic interpretation of one or another of the great guarantees in the Bill of Rights. They more or less limit the liberty of the individual or they diminish property to a certain extent. We have few scientifically certain criteria of legislation, and as it often is difficult

> to mark the line where what is called the police power of the States is limited by the Constitution of the United States, judges should be slow to read into the latter a *nolumus mutare* as against the law-making power. *Noble State Bank v. Haskell*, 219 U.S. 104, 110 (1911).

The question of standing always looms in the background of an equal protection claim. It is axiomatic that one does not have standing to assert the rights of another. *Tileston v. Ullman*, 318 U.S. 44 (1943). In order to satisfy the constitutional requirement for a case or controversy

> [t]he controversy must be definite and concrete, touching the legal relations of parties having adverse legal interests. *Aetna Life Insurance Co. v. Haworth*, 300 U.S. 22., 240 (1937).

Plaintiffs also raise a vagueness issue under the due process claim.

1. *Residence and Place of Employment*

Plaintiffs complain that the statute discriminates against them by "compelling only those who are residents and have their principal place of employment in New Hampshire to procure mental health insurance . . . "

Chapter 57:1(I) of the 1976 Laws states in pertinent part:

> Each insurer . . . shall provide to each group, or the portion of each group comprised of certificate holders of such insurance *who are residents of this state and whose principal place of employment is in this state*, coverage for expenses arising from the treatment of mental illness . . . (Emphasis added.)

The statute, far from discriminating, applies equally to all those within the jurisdiction. It is basic constitutional law that a state can only regulate as to those within its jurisdiction. While this may impose additional burdens on residents as opposed to those outside the jurisdiction, this is not a constitutional defect.

2. *Blue Cross-Blue Shield*

Plaintiffs complain that Blue Cross-Blue Shield is granted significant advantage over other insurers by Chapter 57:2(VI) of the Laws of 1976 which states:

> In the case of care and services rendered by licensed general hospitals, public or licensed mental hospitals, or community mental health centers which have not entered into a written

> contract with the hospital service corporation for the rendering of such care and services to its subscribers, benefits of not less than ,75 percent of the benefits enumerated in paragraphs I, II, and III shall be provided.

The plaintiffs are not insurance companies, so, even if this provision does discriminate, they are not in a position to complain. If Blue Cross-Blue Shield is given a superior position as a result of this statute, the plaintiffs are free to do business with Blue Cross-Blue Shield. In short, plaintiffs do not have standing to raise this issue.

3. *Group Versus Individual Policies*

Chapter 57:1(I) of the 1976 Laws creates a statutory classification of "group or blanket accident or health insurance policies." The plaintiffs allege that it is unconstitutional to require purchasers of group insurance to purchase mental health insurance since there is no similar requirement for purchasers of individual policies.

The issue is whether there is a rational basis for the mental health insurance requirement for purchasers of group insurance.

The State has determined that there is a grave need for mental health insurance but, because of the higher cost of individual policies, mental insurance benefits are more likely to be economically feasible in a group plan which can take advantage of group, rather than national, actuarial statistics and the combined economic power of the group. This is clearly "a rational basis."

4. *Difference Between Billing Procedures for Psychiatrists and Psychologists from Other Physicians*

Plaintiffs complain that the billing procedures mandated for psychiatrists and psychologists are different from those of physicians and, therefore, unconstitutional. Plaintiffs are not physicians and do not have standing to raise this issue.

5. *First Dollar Charges*

Plaintiffs claim an equal protection violation by Section 1(III) (d) of Chapter 57 of the 1976 Laws which states:

> Benefits for outpatient services under this paragraph need not be provided for the first or second visit providing such a limitation applies in the case of services for other illnesses, and benefits for outpatient treatment may be otherwise limited to not less than 15 full hours of treatment in any consecutive 12-month period.

Plaintiffs interpret this statute to mean that "first and second office visits must be paid unless there are at least 15 full hours of insured mental health treatment in any 12-month period." They contend that there is a distinction made between mental illness and other illnesses and that there must be a rational basis for this distinction. Although I do not concur with plaintiffs' interpretation of the statute, it is plain that the provision does make a distinction between the two categories of illness. This is not a distinction that violates the Equal Protection Clause of the Fourteenth Amendment. The legislature, in its wisdom, has seen fit to give more protection to those with mental problems than those with physical problems. Perhaps they felt that those with physical problems already had adequate protection without further legislative intervention; perhaps they felt that the risk sharing element of insurance should be applied to mental illnesses because of the large expenses incurred by a victim and his family and the potential exposure of all families. In any event, there is a rational basis for this provision which falls within the police power of the State of New Hampshire.

6. *Vagueness*

The plaintiffs allege that Chapter 57 violates the Due Process Clause of the Fourteenth Amendment because it is unduly vague. They contend that N. H. RSA 400-A:15(III), which makes it a crime to violate rules, regulations or order of the Insurance Commissioner, applies to them.[1] It is not clear that

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[1] The statute is set out below.

400-A:15 Rules and Regulations; Violations

I. The commissioner shall have full power and authority to make, promulgate, amend and rescind reasonable rules and regulations for, or as an aid to, the administration or effectuation of any provision or provisions of this title and such other rules and regulations as are reasonably necessary to implement the provisions of this title.

II. Prior to the adoption of any rule or regulation, or the amendment or repeal thereof, the commissioner shall publish or otherwise circulate notice of his intended

this criminal statute applies to insurance statutes as opposed to rules. If it does, the violator would be the insurance carrier, not the plaintiffs' here. Therefore, once again, plaintiffs do not have standing to sue.

7. *Impairment of Contract*

Plaintiffs allege that Chapter 57 impairs their constitutional right to contract. In *City of El Paso v. Simmons*, 379 U.S. 497 (1965), the Court held that the constitutional prohibition against impairment of contracts is qualified by the measure of control which the states retain over remedial processes and that the states also have authority to safeguard vital interests of their citizens even if legislation appropriate to that end has the effect of modifying or abrogating contracts already in effect. That holding is directly on point here.

8. *Interstate Commerce and Preemption*

Plaintiffs' final constitutional claim is that Chapter 57 interferes with Congress' authority to regulate interstate commerce. This constitutional issue is much the same as the preemption issue. The question is whether Congress has chosen to preempt the field.

> [F]ederal regulation of a field of commerce should not be deemed preemptive of state regulatory power in the absence of persuasive reasons — either that the nature of the regulated subject matter permits no other conclusion, or that the Congress has unmistakably so ordained. *Florida Avocado Growers v. Paul*, 373 U.S. 132 (1962).

All of the plaintiff trusts except the New Hampshire Employers' Benefit Trust are Taft-Hartley Trusts and subject to the various provisions of Title 29. Plaintiffs complain that Chapter 57 has been preempted on two separate bases: (a) it interferes with the congressional purpose in ERISA by fostering

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action and afford interested persons opportunity to submit data or views either orally or in writing.

III. Any person who knowingly violates any rule, regulation, or order of the commissioner may, upon hearing, except where other penalty is expressly provided, be subject to such suspension or revocation of certificate of authority or license, or administrative fine not to exceed $2,500 in lieu of such suspension or revocation, as may be applicable under this title for violation of the provision to which such rule, regulation, or order relates.

conflicting state laws; and (b) it is specifically preempted by statute.

a. *Conflicting State Statutes*

The trusts in question here are subject to the provisions of 29 U.S.C. § 186. Subsection (c) (5) of that section provides that monies paid to the fund be used "for the sole and exclusive benefit of the employees of such employer, and their families and dependents . . . " This language has been construed to require fair and equal administration by the fiduciaries of such funds. *Bey v. Muldoon*, 223 F. Supp. 489 (E.D. Pa. 1963).

The beneficiaries of the funds in this case are not all from New Hampshire. They are, therefore, not within the scope of Chapter 57. Plaintiffs assert that if Chapter 57 is followed for New Hampshire beneficiaries, then it must be followed for all beneficiaries. This not only extends New Hampshire jurisdiction beyond its territorial limit, but it runs the risk of conflicting with other jurisdictions which might have different insurance requirements.

This argument is flawed by a false premise. Plaintiffs have attempted a quantum leap by asserting that the requirement of fair and equal administration means that beneficiaries from different jurisdictions must all receive the same precise policies. There is no legal basis for this presumption. The evidence shows that employer and employee contributions to the funds are negotiated by the international unions and that the exact terms of the insurance contracts are chosen by the members of one or more locals. I don't doubt that the State of New Hampshire has created an additional burden for the administrators who may have to furnish two separate plans for the members of each local which is comprised of employees from more than one jurisdiction, but Congress would not have knowingly preempted the insurance field without providing for it more specifically.

b. *Statutory Preemption*

Plaintiffs' other preemption argument is somewhat more direct.

Section 514 of the Employee Retirement Income Security Act (ERISA), 29 U.S.C. § 1144, preempts state laws that relate "to any employee benefit plan . . . "

> [T]he provisions of this title . . . shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan . . . 29 U.S.C. § 1144(a).

Employee benefit plans include both retirement funds and health and accident funds of the type which the plaintiffs administer. 29 U.S.C. § 1002(3).

To the sweeping preemption language, Congress created an exception:

> Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities. 29 U.S.C. § 1144(b) (2) (A).

Plaintiffs claim that there is an exception to this exception contained at 29 U.S.C. § 1144(b) (2) (B).

> Neither an employee benefit plan . . ., nor any trust established under such plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company, or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

There is little or no published legislative history surrounding the words in this subsection which help me interpret it.[2] Plaintiffs would have me read this language to preempt Chapter 57, but the plain meaning of the language is

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2. I have reviewed the parts of the House, Senate, and Conference Reports which concern preemption as well as the hearings before the respective House and Senate Committees and the floor statements of Senator Harrison Williams and Representative John Dent, Chairmen of their respective committees, and statements of other Congressmen. None of these addressed the question of preemption of substantive insurance statutes which regulate benefits, not financial or recording requirements. The complete lack of discussion of the effect of preemption of state regulations which concern actual insurance benefits aids in my conclusion that there was no preemption intended in this field.

that states may not regulate employee benefit plans by calling them insurance companies. This more limited reading is bolstered by 15 U.S.C. § 1012(B).

> No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance . . . 15 U.S.C. § 1012(B).

ERISA is not primarily concerned with the regulation of insurance. ERISA is a broad act, the parts of which are important here deal almost exclusively with reporting provisions to ensure the financial health of employee benefit trusts. The remainder of ERISA deals mostly with tax aspects of retirement funds, contributions to them, and payments from them. Even without the exception for insurance regulation at 29 U.S.C. § 1144(b) (2) (A), the effect of 15 U.S.C. § 1012 is to except insurance regulation from preemption. The exception makes the intent not to preempt even clearer.

The New Hampshire statute imposes mental health insurance on those participating in group insurance plans. It neither seeks to nor in any way affects the administration of employee benefit plans. This decision is distinguished from the rulings in *Azzaro, et al v. Harnett*, C. 75-361 (S.D. N. Y. 1976), and *Hewlett-Packard Co. v. Barnes*, C. 76-1607 (N.D. Cal. 1976), because the state statutes in those cases were financial disclosure, quality control, and general reporting statutes, not general insurance statutes regulating the form of benefits. They were designed to affect the administration and implementation of group plans and were directly preempted by ERISA.

Judgment is entered for the defendant on all counts.

SO ORDERED.

HUGH H. BOWNES
United States District Judge

February 11, 1976

cc: David L. Nixon, Esq.
James C. Sargent, Jr., Esq.
Eugene Van Loan, III, Esq.
John J. Flaherty, Esq.

Constitution of the United States Article VI, second paragraph:

"This Constitution, and the Laws of the United States which shall be made in Pursuance thereof; and all Treaties made, or which shall be made, under the Authority of the United States shall be the supreme Law of the Land; and the Judges in every State shall be bound thereby, any thing in the Constitution or Laws of any State to the Contrary notwithstanding."

Title 29 U.S.C. § 1144

(a) Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

(b) (1) This section shall not apply with respect to any cause of action which arose, or any act or omission which occurred, before January 1, 1975.

(2) (A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

(B) Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (Other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

(3) Nothing in this section shall be construed to prohibit

use by the Secretary of services or facilities of a State agency as permitted under section 1136 of this title.

(4) Subsection (a) of this section shall not apply to any generally applicable criminal law of a State.

(c) For purposes of this section:

(1) The term "State law" includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State. A law of the United States applicable only to the District of Columbia shall be treated as a State law rather than a law of the United States.

(2) The term "State" includes a State, any political subdivision thereof, or any agency or instrumentality of either, which purports to regulate, directly or indirectly, the terms and conditions of employee benefit plans covered by this subchapter.

29 C.F.R. Section 2510.3-1(j) (1976):

(j) Certain group or group-type insurance programs.

For purposes of Title I of the Act and this chapter, the terms "employee welfare benefit plan" and "welfare plan" shall not include a group or group-type insurance program offered by an insurer to employees or members of an employee organization, under which:

(1) no contributions are made by an employer or employee organization;

(2) participation in the program is completely voluntary for employees or members;

(3) the sole functions of the employer or employee organization with respect to the program are, without endorsing the program, to permit the insurer to publicize the program to employees or members, to collect premiums through payroll deductions or dues checkoffs and to remit them to the insurer; and

(4) the employer or employee organization receives no consideration in the form of cash or otherwise in connection

with the program, other than reasonable compensation, excluding any profit, for administrative services actually rendered in connection with payroll deductions or dues checkoffs.

42 F.R. 27425 (5/27/77):

Under paragraph (g), plan procedures for review of claim denials must include the right of a claimant to request review, have representation, review pertinent documents relating to the denial and submit issues and comments in writing. The decision on review must be made by an appropriate "named fiduciary" as defined in section 402(a)(2) of the Act. Where review and final decision on claims is performed by an insurance company, insurance service or similar organization as provided in a plan's claims procedure, the insurance organization is the "named fiduciary." In other cases, the plan must designate (pursuant to section 402(a)(1) the person who has the authority to make the final decision on review.

Chapter 57

HB 4

STATE OF NEW HAMPSHIRE

In the year of Our Lord one thousand nine hundred and seventy-six

AN ACT

to alter the minimum mental illness coverage requirements under major medical and non-major medical accident and health insurance and to decrease grants to community mental health services.

Be it Enacted by the Senate and House of Representatives in General Court convened:

57:1 Minimum Coverage for Mental or Nervous Conditions in Health and Accident Insurance Policies. Amend RSA 415:18-a (supp) as inserted by 1975, 349:1 by striking out said section and inserting in place thereof the following:

415:18-a Coverage for Mental or Nervous Conditions Required.

I. Each insurer that issues or renews any policy of group or blanket accident or health insurance providing benefits for medical or hospital expenses, shall provide to each group, or to the portion of each group comprised of certificate holders of such insurance who are residents of this state and whose principal place of employment is in this state, coverage for expenses arising from the treatment of mental illnesses and emotional disorders which, in the professional judgment of psychiatrists and psychologists, are subject to significant improvement through short-term therapy, and benefits for expenses arising from diagnosis and evaluation of all other mental illnesses and emotional disorders. Such benefits shall be at least as favorable to the certificate holder as the minimum benefits specified in paragraphs II, III and IV.

II. In the case of policies or certificates providing benefits for hospital expenses on other than a major medical basis,

benefits based upon confinement in a licensed or accredited general hospital, including psychiatric inpatient facilities included under the license of such a hospital, shall be at least as favorable as benefits provided for any other illness in such a hospital; and benefits based upon confinement in a public mental hospital shall be at least as favorable as benefits provided for confinement in a licensed or accredited general hospital.

III. In the case of policies or certificates providing benefits for medical expenses on other than a major medical basis:

(a) Benefits for services of a psychiatrist or psychologist, who customarily bills patients directly shall be subject to terms and conditions at least as favorable as those which apply to the benefits for the services of physicians for other illnesses, and the ratio of the benefits to the fees reasonably and customarily charged for the services of such psychiatrists or psychologists shall be substantially the same as the ratio of the benefits for services of physicians for other illnesses to the fees reasonably and customarily charged for the services of such physicians for other illnesses.

(b) Benefits for services rendered at a community mental health center approved by the division of mental health, department of health and welfare, shall be subject to terms and conditions at least as favorable as those which apply to the benefits for the treatment of other illnesses, and the ratio of the benefits to the full reasonable charges for the services of such a center shall be substantially the same as the ratio of the benefits for services of physicians for other illnesses to the fees reasonably and customarily charged for the services of such physicians for other illnesses.

(c) Benefits for outpatient services rendered at a public mental hospital shall be subject to terms and conditions at least as favorable as those which apply to the benefits for the treatment of other illnesses, and the ratio of the benefits to the fees reasonably and customarily charged for the services of such a hospital shall be substantially the same as the ratio of the benefits for services of physicians for other illnesses to the fees

reasonably and customarily charged for the services of such physicians for other illnesses.

(d) Benefits for outpatient services under this paragraph need not be provided for the first or second visit providing such a limitation applies in the case of services for other illnesses, and benefits for outpatient treatment may be otherwise limited to not less than 15 full hours of treatment in any consecutive 12-month period.

IV. In the case of policies or certificates providing benefits for hospital and medical expenses on a major medical basis, benefits shall be subject to deductibles and co-insurance at least as favorable as those which apply to the benefits for any other illness, provided that benefits payable for expenses incurred in any consecutive 12-month period may be limited to an amount not less than $3,000 per covered individual, and to a lifetime maximum of not less than $10,000 per covered individual. In this paragraph, covered major medical expenses include the reasonable charges for services and treatment on an inpatient, outpatient or partial hospitalization basis by a psychiatrist, a psychologist, a licensed general hospital, a public or licensed mental hospital, or a community mental health center approved by the division of mental health, department of health and welfare.

V. In this section:

(a) "Psychiatrist" means a licensed physician who is board-certified or board-eligible according to the most recently promulgated regulations of the American Board of Psychiatry and Neurology.

(b) "Psychologist" means an individual who is certified under RSA 330-A, or under a similar statute in another state, and who is either listed in the National Register of Health Service Providers in Psychology or is a diplomate in clinical psychology through the American Board of Professional Psychologists.

57:2 Minimum Coverage for Mental or Nervous Conditions

in Hospital Service Corporation Contracts. Amend RSA 419:5-a (supp) as inserted by 1975, 349:2 by striking out said section and inserting in place thereof the following:

419:5-a Coverage for Mental or Nervous Conditions Required.

I. Every hospital service corporation, and every other similar corporation licensed under the laws of another state, shall provide to each group, or to the portion of each group comprised of certificate holders of such insurance who are residents of this state and whose principal place of employment is in this state, coverage for expenses arising from the treatment of mental illnesses and emotional disorders which, in the professional judgment of psychiatrists and psychologists, are subject to significant improvement through short-term therapy, and benefits for expenses arising from diagnosis and evaluation of all other mental illnesses and emotional disorders. Such benefits shall be at least as favorable to the certificate holder as the minimum benefits specified in paragraphs II and III.

II. In the case of policies or certificates providing benefits for hospital expenses on other than a major medical basis, benefits based upon confinement in a licensed or accredited general hospital, or in psychiatric inpatient facilities included in the license of such a hospital, shall be at least as favorable as benefits provided for any other illness; and benefits based upon confinement in a public mental hospital shall be at least as favorable as benefits provided for confinement in a licensed or accredited general hospital.

III. In the case of policies or certificates providing benefits for hospital expenses on a major medical basis, benefits shall be subject to deductibles and coinsurance at least as favorable as those which apply to the benefits for any other illness, provided that benefits payable for expenses incurred in any consecutive 12-month period may be limited to an amount not less than $3,000 per covered individual, and to a lifetime maximum of not less than $10,000 per covered individual. If such a policy or certificate is issued jointly with a medical service corporation

licensed under RSA 420 or a health service corporation licensed under RSA 420-A, the limit on benefits payable for expenses incurred by any covered individual in any consecutive 12-month period and the limit on lifetime benefits may apply to the total benefits for mental illnesses and emotional disorders provided under such policy or certificate for such individual. In this paragraph, covered major medical expenses include the reasonable charges for services and treatment on an inpatient, outpatient or partial hospitalization basis by a licensed general hospital, a public or licensed mental hospital, or a community mental health center approved by the division of mental health, department of health and welfare; except that such expenses may exclude charges arising from the professional services of a psychiatrist or a psychologist who customarily bills patients directly rather than to a hospital or community mental health center.

IV. In this section:

(a) "Psychiatrist" means a licensed physician who is board-certified or board-eligible according to the most recently promulgated regulations of the American Board of Psychiatry and Neurology.

(b) "Psychologist" means an individual who is certified under RSA 330-A, or under similar statute in another state, and who is either listed in the National Register of Health Service Providers in Psychology or is a diplomate in clinical psychology through the American Board of Professional Psychologists.

V. Benefits under this section shall be provided for care and services rendered by those licensed general hospitals, public or licensed mental hospitals, or community mental health centers which have entered into a written contract with the hospital service corporation for the rendering of such care and services

VI. In the case of care and services rendered by licensed general hospitals, public or licensed mental hospitals, or community mental health centers which have not entered into a written contract with the hospital service corporation for the

rendering of such care and services to its subscribers, benefits of not less than 75 percent of the benefits enumerated in paragraph I, II, and III shall be provided.

57:3 Minimum Coverage for Mental or Nervous Conditions in Medical Service Corporation Contracts. Amend RSA 420:5-a (supp) as inserted by 1975, 349:3 by striking out said section and inserting in place thereof the following:

420:5-a Coverage for Mental or Nervous Conditions Required.

I. Every medical service corporation, and every other similar corporation licensed under the laws of another state, shall provide to each group, or to the portion of each group comprised of certificate holders of such insurance who are residents of this state and whose principal place of employment is in this state, coverage for expenses arising from the treatment of mental illnesses and emotional disorders which, in the professional judgment of psychiatrists and psychologists, are subject to significant improvement through short-term therapy, and benefits for expenses arising from diagnosis and evaluation of all other mental illnesses and emotional disorders. Such benefits shall be at least as favorable to the certificate holder as the minimum benefits specified in paragraphs II and III.

II. In the case of policies or certificates providing benefits for medical expenses on other than a major medical basis:

(a) Benefits for services of a psychiatrist or psychologist, who customarily bills patients directly shall be subject to terms and conditions at least as favorable as those which apply to the benefits for the services of physicians for other illnesses, and the ratio of the benefits to the fees reasonably and customarily charged for the services of such psychiatrists or psychologists shall be substantially the same as the ratio of the benefits for services of physicians for other illnesses to the fees reasonably and customarily charged for the services of such physicians for other illnesses.

(b) Benefits for services rendered at a community mental health center approved by the division of mental health, department of health and welfare, shall be subject to terms and conditions at least as favorable as those which apply to the benefits for the treatment of other illnesses, and the ratio of the benefits to the full reasonable charges for the services of such a center shall be substantially the same as the ratio of the benefits for services of physicians for other illnesses to the fees reasonably and customarily charged for the services of such physicians for other illnesses.

(c) Benefits for outpatient services rendered at a public mental hospital shall be subject to terms and conditions at least as favorable as those which apply to the benefits for the treatment of other illnesses, and the ratio of the benefits to the fees reasonably and customarily charged for the services of such a hospital shall be substantially the same as the ratio of the benefits for services of physicians for other illnesses to the fees reasonably and customarily charged for the services of such physicians for other illnesses.

(d) Benefits for outpatient services under this paragraph need not be provided for the first or second visit providing such a limitation applies in the case of services for other illnesses, and benefits for outpatient treatment may be otherwise limited to not less than 15 full hours of treatment in any consecutive 12-month period.

III. In the case of policies or certificates providing benefits for medical expenses on a major medical basis, benefits shall be subject to deductibles and coinsurance at least as favorable as those which apply to the benefits for any other illness, provided that benefits payable for expenses incurred in any consecutive 12-month period may be limited to an amount not less than $3,000 per covered individual, and to a lifetime maximum of not less than $10,000 per covered individual. If such a policy or certificate is issued jointly with a hospital service corporation licensed under RSA 419 or a health service corporation licensed

under RSA 420-A, the limit on benefits payable for expenses incurred by any covered individual in any consecutive 12-month period and the limit on lifetime benefits may apply to the total benefits for mental illnesses and emotional disorders provided under such policy or certificate for such individual. In this paragraph, covered major medical expenses include the reasonable charges of a psychiatrist or psychologist who customarily bills patients directly.

IV. In this section:

(a) "Psychiatrist" means a licensed physician who is board-certified or board-eligible according to the most recently promulgated regulations of the American Board of Psychiatry and Neurology.

(b) "Psychologist" means an individual who is certified under RSA 330-A, or under a similar statute in another state, and who is either listed in the National Register of Health Service providers in Psychology or is a diplomate in clinical psychology through the American Board of Professional Psychologists.

57:4 Transition. Notwithstanding RSA 415:18-a, RSA 419:5-a and RSA 420:5-a, as inserted by sections 1, 2 and 3 of this act, respectively, no policy or certificate issued thereunder issued by an accident and health insurer, a hospital service corporation or a medical service corporation, in effect on the effective date of this act, shall be required to provide benefits required by this act until the first day of the first month following 90 days after passage of this act.

57:5 Implementation. Upon passage of this act, the insurance commissioner shall review the rates currently charged by every medical service corporation and by every hospital service corporation and shall, where appropriate, take steps to assure a prompt revision of rates due to the revision of required

coverage for mental or nervous conditions. Any such revision shall be made and shall become effective within 90 days following passage of this act.

57:6 Grants to Community Mental Health Services Decreased. Amend 1975, 505:1.05, 03, 04, 01, 02 by striking out same and inserting in place thereof the following:

02	Grants to community mental health services:			
90	Grants to community health services*	3,524,045	3,492,048	
Total		3,524,045		3,492,048
Estimated source of funds for grants to community mental health services:				
00	Federal	85,500		85,500
	General Fund	3,438,545		3,406,548
Total		3,524,045		3,492,048

*These funds shall not be expended for any other purpose, shall be non-lapsing in the first year of the biennium, and if sufficient funds are not available for both years of the biennium for full implementation, these funds shall be prorated. $200,000 of the fiscal year 1976 and the fiscal year 1977 appropriations shall be improvement grants for the centers known as Salem, Lakes Region, Monadnock, and Seacoast.

57:7 Effective Date. This act shall take effect upon its passage.

Approved. Enacted in accordance with Article 44, Pt. II of N.H. Constitution, without signature of governor, June 4, 1976. Effective date June 4, 1976.